

SENDER: COMPLETE THIS SECTION

- ☐ Complete items 1, 2, and 3 if Restricted Delivery is desired.
☐ Print your name and address on the reverse so that we can return the item to you.

Medical Nursing Supervisor
 Mont. County Det. Facility
 P.O. Box 4599
 Montgomery, AL 36197

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent ☐ Addressee
 X *A Brown*
 B. Received by (Printed Name) *A Brown* C. Date of Delivery *6/2/06*
 Delivery address different from item 1? ☐ Yes
 If Yes, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.
 4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
 15 21 8026

005...2820...0002...346...1884...11

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540